Member Information

Eligibility for Family Care

Individuals are required to meet both functional and financial eligibility criteria to qualify for Family Care.

Family Care covers adults 18 years and older who have long term care needs, specifically:

- Elderly persons.
- Persons with physical disabilities.
- Persons with developmental disabilities.

Specific target groups served vary among the pilot projects.

Individuals are required to meet both functional and financial eligibility criteria to qualify for Family Care. Individuals who meet the Family Care eligibility criteria are not necessarily eligible for Medicaid (refer to Members Who Are Not Eligible for Medicaid in this chapter for more information).

Providers should refer individuals who may benefit from information on long term care to their local Resource Center, whether or not the individuals are eligible for Medicaid.

Functional Eligibility Criteria

Functional eligibility is based on the degree to which an individual can independently manage the activities of daily living, such as mobility and eating, and/or instrumental activities of daily living, such as money management or arranging transportation. The Long Term Care Functional Screen, administered by Resource Center staff, determines functional eligibility.

Financial Eligibility Criteria

Besides functional eligibility criteria, individuals must also meet certain financial thresholds to be eligible for Family Care. Medicaid-eligible individuals automatically meet the financial criteria for Family Care. Individuals who are not financially eligible for Medicaid may still qualify for Family Care based on their cost of care.

Individuals receiving the Family Care benefit may be required to pay a cost share to the care management organization (CMO). Except for the functional eligibility determination made at the Resource Center, all other eligibility determinations, and cost-share, are determined at the county Economic Support Unit. (Refer to the Billing for Medicaid-Eligible Members chapter in this guide for more information on cost-share.)

How Are Individuals Enrolled in Care Management Organizations?

Resource Center staff offer counseling on available long term care options, including the Family Care benefit. If the individual is eligible for Family Care and chooses to participate in Family Care, he or she enrolls in a CMO. Resource Center staff and/or Family Care enrollment brokers will help the individual complete the necessary paperwork for enrolling in a CMO. Individuals enrolled in CMOs are referred to as *members*.

Note: The Family Care benefit is only available through the CMO. Members may disenroll from a CMO at any time during the month, but they no longer receive the Family Care benefit once they disenroll.

Identification and Verification of Members Who Are Eligible for Medicaid

Identification

Medicaid-eligible Family Care members receive Wisconsin Medicaid Forward cards. Since members can enroll in, or disenroll from, a CMO ***at any time*** during the month, providers should ***always*** verify member

eligibility before providing services. Providers may access eligibility information through the Automated Voice Response (AVR) system or through an eligibility verification vendor.

Refer to the Provider Resources section of the All-Provider Handbook for detailed information on the methods of verifying eligibility.

Verification Through the Automated Voice Response System

The AVR system will state:

1. That the member is enrolled in Family Care.
2. The CMO's telephone number.

The AVR will respond, "For this period, recipient is enrolled in the Family Care program, this is not an HMO. The phone number is <phone number>. For additional assistance in determining Family Care benefits, press 0."

Verification Through Eligibility Verification Vendors

Eligibility verification vendors (e.g., magnetic stripe card readers or computer software) will provide:

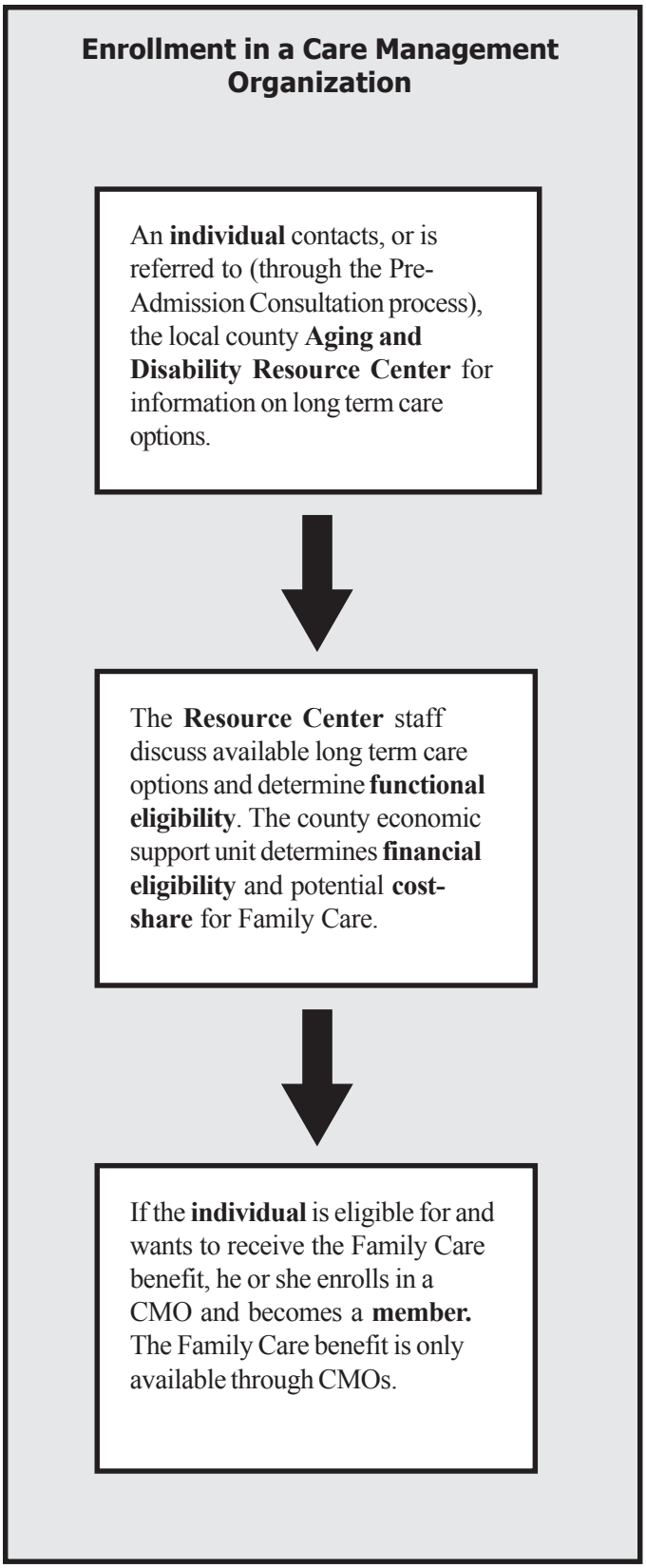
1. The CMO's name and telephone number.
2. The message "Family Care Program."

Members Who Are Not Eligible for Medicaid

Individuals who do not meet the eligibility criteria for Medicaid may still meet the functional and financial criteria to enroll in a CMO. As with Medicaid-eligible individuals, individuals who do not qualify for Medicaid are required to enroll in a CMO to receive the Family Care benefit.

These members:

- Receive CMO services included in the Family Care benefit package (refer to the Service Information chapter of this guide



for information on services included in the Family Care benefit package).
- May receive services that are not included in the Family Care benefit package. Wisconsin Medicaid will not reimburse services provided to CMO members who are not eligible for Medicaid. The member, the member's commercial health insurance, or Medicare (if the member has Medicare coverage) is responsible for reimbursing the provider for services that are not included in the Family Care benefit package.

Care Management Organization members who are not eligible for Medicaid will be assigned an identification number but will *not* receive Forward cards.

Providers should bill non-Medicaid-eligible members or their commercial health insurance for any services that are not included in the Family Care benefit package. Medicaid does not reimburse for Medicaid services provided to CMO members who are not eligible for Medicaid.

Providers with questions about CMO members who are not eligible for Medicaid should contact the appropriate CMO at the number listed in Appendix 1 of this guide.

Refer to Appendix 5 of this guide for an illustration of how eligibility and covered services differ between members who are eligible for Medicaid fee-for-service and members who are not eligible for Medicaid fee-for-service.

Identification

Care Management Organization members who are not eligible for Medicaid will be assigned an identification number but will *not* receive Forward cards. However, any members who were previously eligible for Medicaid may still have Forward cards.

For members who do not have Forward cards, providers may verify Family Care eligibility through the AVR or an eligibility verification vendor method by entering the members' identification number into the system.

To obtain the identification number of members who do not have existing Forward cards, providers may:

- Contact Wisconsin Medicaid's Provider Services (telephone correspondents) at (800) 947-9627 or (608) 221-9883.
- Contact the member's CMO (refer to Appendix 1 of this guide for a list of CMO contact numbers).

Verification Through the Automated Voice Response System

When verifying Family Care eligibility for members who are not eligible for Medicaid, the AVR system will state:

1. That the member is enrolled in Family Care.
2. The CMO's telephone number.

The AVR system will state "For this period, recipient is eligible only for services provided by the Family Care program. No Medicaid card services are available."

As with Medicaid-eligible members, the AVR system also responds "For this period, recipient is enrolled in the Family Care program, this is not an HMO. The phone number is <phone number>. For additional assistance in determining Family Care benefits, press 0."

Verification Through Eligibility Verification Vendors

Eligibility verification vendors will provide:

1. The CMO's name and telephone number.
2. The message, "Family Care Program."

Eligibility verification vendors will also indicate "Services through Family Care prog. Not eligible for Medicaid card services."

Estate Recovery

Members and Estate Recovery

As with other long term care programs, Family Care benefits are subject to estate recovery. Amounts recovered are returned to the State and used for the benefit of other participants.

Recovery can be made for the following services when they were received on or after February 1, 2000:

- For CMO members age 55 or older who reside in the community, the cost of the following benefits received by the members while enrolled in a CMO:
  - √ All services provided through the CMO.
  - √ All inpatient hospital services.
  - √ All prescription/legend drugs.
- For CMO members of any age who live in inpatient hospitals and contribute to their cost of care, and members who live in nursing facilities, the cost of all services that were received during such stays may be recovered.

The recoverable amount is the actual cost of the service as reported to the Department of Health and Family Services (DHFS) by the CMO.

Services that are recoverable for both Medicaid-eligible members and those members who are not eligible for Medicaid is the same as for other home and community-based waiver programs or Medicaid waiver services. Recovery may be made through the member's estate and also through a lien on the home of a member who lives in a hospital and is required to contribute to the cost of care, or who lives in a nursing facility and is not reasonably expected to return home to live. **Liens are not placed on homes of members living in the community.**

Providers and Estate Recovery

Providers are not required to take any action concerning estate recovery. Refer members to their local Aging and Disability Resource Center or local county or tribal social or human services department for more information.

Member Complaints and Grievances

Members have the right to voice their dissatisfaction about services arranged or provided by a CMO and to grieve CMO decisions to deny, reduce, or terminate any services.

Members have three options for filing complaints or grievances:

- Members may submit a complaint or grievance to the CMO (all CMOs must have written policies and procedures in place to handle member complaints and grievances).
- Members may submit a written complaint or grievance directly to the DHFS before, during, or after using the CMO complaint or grievance process.
- Members may file a grievance through the state fair hearing process before, during, or after using the CMO and/or DHFS complaint or grievance process.

Members have the right to voice their dissatisfaction about services arranged or provided by a CMO and to grieve CMO decisions to deny, reduce, or terminate any services.

Provider Assistance for Member Complaints and Grievances

Care Management Organization members may ask professional advocates or other persons, including providers, to assist or represent them in these situations. Providers can file a complaint or grievance on behalf of a CMO member.

Refer to Appendix 3 of this guide for a list of complaints and grievance contacts at the DHFS and the Division of Hearings and Appeals (for the state fair hearings process).